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**Summary of mid-term reviews and major evaluations of
country programmes****Eastern and Southern Africa region***Summary*

The present report was prepared in response to Executive Board decision 1995/8 (E/ICEF/1995/9/Rev.1), which requested the secretariat to submit to the Board a summary of the outcome of mid-term reviews (MTRs) and major country programme evaluations, specifying, inter alia, the results achieved, lessons learned and the need for any adjustments in the country programme. The Board is to comment on the reports and provide guidance to the secretariat, if necessary. The MTRs and evaluations described in this report were conducted during 2003, with some finalized in early 2004.

Introduction

1. In 2003, UNICEF had programmes in 21 countries and in southern Sudan, in Eastern and Southern Africa. Of these, Namibia, Rwanda, Swaziland and Uganda conducted mid-term reviews (MTRs). These MTRs assessed progress and results compared with baselines and objectives in country notes and master plans of operations (MPOs); in Namibia, a joint United Nations Review was conducted. The MTRs also provided an update on the situation of children and women in each country. The MTR reports describe agreements with counterparts and other partners on adjustments to programme objectives and strategies.

* E/ICEF/2004/12.



2. A total of 260 studies, reviews, assessments and evaluations were carried out by country offices in 2003, covering all priorities of the medium-term strategic plan (MTSP). One or two high-quality examples from each MTSP area were selected for inclusion in this report. These are from Madagascar (early childhood development (ECD) and immunization), Malawi and Zambia (fighting HIV/AIDS), United Republic of Tanzania (girls' education), and Southern Africa (protection).

Mid-term reviews

Namibia

3. **Introduction.** The Namibia-UNICEF country programme of cooperation 2002-2005 is harmonized with the cycles of other United Nations agencies. In late 2003, each agency undertook an MTR with government and non-governmental organization (NGO) counterparts. This was followed by a joint mid-term review of the United Nations Development Assistance Framework (UNDAF) in early 2004.

4. The Government of Namibia-UNICEF review included 11 studies and evaluations, an updated situation analysis, an assessment of progress in each MTSP area, and programme reviews with counterparts. The MTR meeting, chaired by the National Planning Commission, approved recommendations from the programme reviews, and made recommendations for the joint UNDAF review. After assessing data in a new joint database of indicators, the UNDAF theme groups drew conclusions on major achievements and lesson learned and made recommendations for the remaining UNDAF cycle and the next. There were strong linkages with the concurrent mid-term reviews of the Second National Development Plan and the National Poverty Reduction Action Plan.

5. **The situation of children and women.** Despite impressive gains in extending social services and improving the policy environment, the steady increase in HIV prevalence is reversing post-Independence advancements. Roughly 150,000-180,000 people out of a total population of 1.8 million are HIV positive. AIDS is a factor in about 40 per cent of under-five deaths. The infant mortality rate (IMR) is currently 52 per 1,000 live births, but is projected to increase to 72 per 1,000 by 2010. The maternal mortality ratio (MMR) rose from 225 to 271 deaths per 100,000 live births between 1992 and 2000. One in seven children under age 15 is an orphan. Around 10 to 20 per cent of workers in the social sector are expected to die within the next five years. Around 39 per cent of 19-year-old females are mothers or are pregnant. The incidence of child-headed households, children living on the street, domestic violence, child abuse and rape is rising.

6. Namibia is a "middle-income" country, but has one of the highest levels of gross inequality (Gini coefficient of 0.70). A large majority of the population lives in poverty. Malnutrition among children remains a major problem (31 per cent stunted, 30 per cent underweight). Namibia's recurrent droughts and periodic floods contribute to poverty, food insecurity, and malnutrition. The effects of the HIV/AIDS epidemic reinforce these problems, putting large numbers of families in a downward spiral that defies their traditional coping mechanisms, and increases pressure on social service provision.

7. Other current concerns are the stagnation in immunization coverage, outbreaks of measles, low (26 per cent) rate of exclusive breastfeeding, lack of growth

monitoring, low (7 per cent) usage of insecticide-treated nets (ITNs), and high rates of death from neonatal causes and from preventable and treatable diseases. ECD is not reflected in national plans, and few community or health workers are trained.

8. At 86 per cent, primary school enrolment is relatively high, and 94 per cent of students enrolled attend for five years. Secondary school enrolment is much lower, with only 43 per cent of children aged 14-18 enrolled. Certain population groups have much lower primary and secondary enrolment rates.

9. **Progress and key results.** The first country programme objective is to strengthen caregivers' capacities and improve the nutritional status of children, reduce their morbidity and improve their learning achievement. A UNICEF study on caring practices contributed to the comprehensive communications strategy now being implemented. The country programme supported the Integrated Management of Childhood Illness (IMCI), the prevention of mother-to-child-transmission (PMTCT) of HIV and ECD through training of service providers and community capacity-building in 10 districts. UNICEF contributed to the passage of the Infant and Young Child Feeding Policy, Adolescent-Friendly Health Services policies and to a Girls' Education Initiative. The programme contributed to a 10-per-cent decrease in teenage pregnancies and increased school enrolment and retention in a region with significant gender disparities. The PMTCT programme expanded to six more sites in 2003, and leveraged support will enable expansion to 34 more sites in 2004.

10. A second programme objective concerns information, appropriate skills and quality services for HIV prevention. A UNICEF study led to a new youth communication strategy and a media campaign. The country programme supported training of mobilizers and facilitators in a life skills project that reached more than 250,000 adolescents and helped reduce prevalence among youth 15-19 years old. The country programme will initiate a similar programme for children 10-14 years old in 2004-2005. Adolescent-friendly health services are now available in 85 facilities (five more than planned) in nine underserved districts, and 100 trained peer counsellors are in place.

11. UNICEF assisted the Government to obtain funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria and plans to leverage its programme work through monies from the Global Fund and the Presidential Emergency Plan for AIDS Relief (United States). These will benefit NGO and community efforts for assisting orphans and other vulnerable children (OVCs), HIV/AIDS communication and social mobilization, training of teachers, and expansion of PMTCT services.

12. The third objective is expanding protection services for vulnerable children and women and eliminating conditions that create or perpetuate disparities. A UNICEF study on exemption from school development fees is being used to develop policies to improve the access of OVCs to education. A UNICEF review of data on child abuse contributed to passage of the 2003 Domestic Violence Bill. Fifteen Women and Child Protection Units were established, police officers were trained in management of abuse, and teachers were trained in psychosocial support for OVCs. The finalized OVC policy and Juvenile Justice Bill are awaiting Cabinet approval. The country programme supported a faith-based organization that assisted OVCs in 68 locations, and attracted new donors. The programme also supported education and other services for orphans in highly affected regions.

13. **Resources used.** Of the total \$1.29 million in regular resources allocated for 2002-2003, \$1.26 million (98 per cent) were spent in the following percentages: young children's health, care and development (21); adolescents and HIV prevention (29); special protection and disparity-reduction (25); and cross-sectoral support (25).

14. A total other resources ceiling of \$6.71 million was set for 2002-2003, of which \$4.64 million (including set-aside funds) were available, and \$4.10 million (88 per cent) were spent in the following percentages: young children's health, care and development (32); adolescents and HIV prevention (41); special protection and disparity-reduction (25); and cross-sectoral support (2). While funds raised in all programme areas fell short of plans, the major shortfall was in the area of young children, with \$1.4 million raised against a \$2.7 million ceiling. Donor focus on HIV/AIDS made fund-raising in other areas problematic. Main donors are the Netherlands, Sweden, the United States, Norway, the International Development Research Centre, the German and Belgian National Committees for UNICEF and GlaxoSmithKline.

15. The country programme contributed to all the MTSP priority areas, with 21 per cent of its budget spent on early childhood, 5 per cent on immunization "plus", 47 per cent on fighting HIV/AIDS, 4 per cent on girls' education and 16 per cent on child protection.

16. **Constraints and opportunities affecting progress.** HIV/AIDS, income disparities and chronic food insecurity are the major constraints. Service delivery is severely impacted by HIV/AIDS, with staff shortages due to absenteeism, death, and migration undermining capacity-building. Weak management capacity in many areas impedes implementation and results in poor monitoring and accounting.

17. Namibia does present many opportunities. High levels of school enrolment and gender parity make realization of the Millennium Development Goals in education feasible. A relatively high literacy rate facilitates communication. The Government invests heavily in social sectors and takes children's issues seriously. National decision makers take action based on well-documented advocacy. The Government works closely with the United Nations; the new Common Country Assessment (CCA)/United Nations Development Assistance Framework (UNDAF), linked to the Poverty Reduction Action Plan, provides opportunities for harmonized, synergetic programming. Decentralization provides opportunities for expanding community and rights-based programming to underserved areas and people.

18. **Adjustments made.** The MTR recommendations required only minor adjustments to the country programme. To promote greater and wider behaviour change, programme communication for social change needs strengthening, with stronger emphasis placed on reaching adults responsible for children. To improve results in protection from violence and abuse, the programme will change its focus from service delivery, the costs of which are increasingly borne by the Government, to prevention through community mobilization.

19. Due to limited capacity for implementation and to funding constraints, support for community IMCI and adolescent-friendly health services will be limited to 12 districts instead of the 18 originally envisioned. Service delivery and social mobilization components will be combined under the adolescent HIV-prevention programme. The Government recently accepted *DevInfo* as the monitoring

mechanism for the Millennium Development Goals and other indicators, and this will be supported to strengthen monitoring.

Rwanda

20. **Introduction.** The MTR was led by the Government through a Steering Committee that included representatives from all of the Ministries involved in the country programme. Using the updated situation analysis, technical staff from the Government, NGO staff and UNICEF reviewed each project's results. Projects were also reviewed at provincial meetings, with a focus on implementation of the human rights-based approach to programming. Findings and recommendations from these reviews were agreed upon at a pre-MTR meeting, and a draft report was distributed. At the final MTR meeting, the 85 participants included most Ministers concerned with the country programme implementation, illustrating the importance given to the country programme. Participants validated conclusions and recommendations and approved adjustments to the MPO.

21. **The situation of children and women.** An updated situation analysis and an analysis of the major changes affecting the legislative and institutional environment for children and women were essential contributions to the MTR. The markedly changed programme implementation context included a new Constitution, elections and the end of the post-genocide transition phase. Many national development instruments were put in place: the Poverty Reduction Strategy Paper (PRSP), Vision 2020, policies and strategies in education, protection of OVCs, health, and decentralization. Rwanda committed to the Millennium Development Goals, *A World Fit for Children* and a new UNDAF. The Government took important steps in the realization of children's rights, in line with the 2002 Report to the Committee on the Rights of the Child.

22. Around 60 per cent of Rwandans live below the poverty line. The IMR and under-five mortality rate (U5M) have declined since the programme began, but are still high at 96 and 183 per 1,000 live births, respectively. The MMR is 1,071 per 100,000 live births. High malnutrition persists, with 24 per cent of under-fives underweight and 43 per cent stunted. HIV prevalence increased from 8.9 per cent to 13 per cent, according to recent sentinel surveillance data. Rwanda has one of the world's highest proportions of OVCs: 1.2 million children are orphans, with 101,000 living in child-headed households and 7,000 living on the street. About 12,000 children work, sometimes in hazardous sectors. A new law established serious penalties for those guilty of sexual abuse and other exploitation, but enforcement remains weak.

23. Since the inception of the country programme, net enrolment rates have increased to 78 per cent, with gender parity achieved. However, girls remain more likely to repeat grades or drop out. Only 38 per cent of children complete primary school.

24. **Progress and results.** The child survival, growth and development programme contributed towards high immunization coverage rates, including near elimination of neonatal tetanus. In six focus districts, ITN use increased by 1 per cent. Vitamin A supplementation was ensured, salt iodization remained high and iron tablet distribution increased. Community-based nutrition surveillance in nine districts monitored 500,000 children, and 108,000 malnourished children were rehabilitated. PMTCT services were scaled up to 45 sites, 14 supported by UNICEF. Water and

environmental sanitation projects covered 217,000 people in 45 communes, 42 primary schools and 5 health centres.

25. The education programme contributed to increasing enrolment rates by nearly 4 per cent, raising primary school completion from 30 to 38 per cent, and decreasing repetition rates from 31 to 17 per cent. The programme helped to transform 16 primary schools with 19,000 children into child-friendly, gender-sensitive environments. UNICEF made important contributions to the Education Sector Strategic Plan, the Education for All Plan and the Gender in Education Review. A UNICEF study on guidance and counselling informed a national strategy promoting access as well as inclusion of psychosocial support and career guidance in schools, especially for girls and vulnerable children. Curricula were improved through the development of teaching materials on HIV/AIDS, civic education and peace and reconciliation.

26. The promulgation of a new law on child rights and protection of children against violence was supported, and the legal framework pertaining to children was reviewed. For children accused of taking part in the genocide, UNICEF advocated for the release of imprisoned children under age 14, reduced sentences for those 14-18, and legal assistance and priority consideration for children in tribunals. Social workers serving imprisoned children were trained.

27. Advocacy efforts kept OVCs high on the development agenda. An important milestone was the adoption of a national OVC policy. UNICEF is working with partners towards a national OVC education programme, including "catch-up" centres. Direct support was given to 15,000 child-headed households, district funds for OVCs were created, and local NGOs were supported to reintegrate children who live or work on the street. Campaigns against child abuse were conducted and a project was launched to fight the worst forms of child labour. UNICEF supported demobilization and reintegration of child soldiers and training of military personnel on child protection and rights.

28. The HIV/AIDS and child participation programme helped increase awareness, reduce stigma, and expand prevention, care and support through life skills curricula and anti-AIDS clubs. Findings from a UNICEF study were used to develop prevention messages. Fostering safer behaviour among out-of-school youth involved training of peer educators, mobilizers, and youth leaders. A strong programme of youth-designed HIV/AIDS responses was established through the rights-based approach and use of decentralized structures.

29. The social planning and rights advocacy programme developed monitoring tools and systems and supported 15 studies and evaluations as well as collection of baseline data. A national statistics system plan was developed, and government capacity in data collection was strengthened. Rwanda *DevInfo* was introduced and is being used to monitor Millennium Development Goals and PRSP goals. Rights promotion and advocacy were furthered through support for the first report to the Committee on the Rights of the Child, the "Say Yes for Children" campaign, and work with donors.

30. **Resources used.** Of the total regular resources of \$9.18 million allocated for 2001-2003, \$8.13 million (89 per cent) was spent in the following percentages: child survival, growth and development (32); education, development and protection (28); HIV/AIDS prevention and child participation (13); social planning and rights advocacy (11) and cross-sectoral support (16).

31. An other resources ceiling of \$14.90 million was set for 2001-2003, of which \$14.12 million was available and \$13.05 million (92 per cent) was spent in the following percentages: child survival, growth and development (54); education, development and protection (40); HIV/AIDS prevention and child participation (2.5); social planning and rights advocacy (.5) and cross-sectoral support (3).

32. Some programme components mobilized other resources beyond planned levels, while projects such as juvenile justice, nutrition, PMTCT and water and sanitation fell short. Recently, the child protection project attracted the largest funding, especially for OVCs and child-headed households. Contributors were the National Committees of the United Kingdom, Switzerland and Germany, the US Fund for UNICEF, the Canadian International Development Agency, Food Aid Centre, the Government of Norway and the Centers for Disease Control and Prevention in the United States. Overall, 91 per cent of available resources were expended, 57 per cent on cash assistance.

33. **Constraints and opportunities affecting progress.** Constraints included weak sectoral coordination and inadequate involvement of children in programming — district leadership needs to be more committed to community participation. Two flaws in the country programme were a weak programme communication strategy and inadequate attention to HIV/AIDS. More funding is needed to scale up successful pilot projects in PMTCT, water and sanitation, improving school quality, alternative education and community-based nutrition surveillance. Birth registration also lacked sufficient support. Other constraints were a lack of reliable data for planning at all levels and weak dissemination of information between sectors. Limited capacity of partners slowed implementation.

34. Children's participation in the fight against HIV/AIDS has been quite effective, and lessons learned can be applied to other programmes. The combination of national and subnational intervention permits both a macro policy influence and effectiveness-testing at local levels. The growing importance of sector-wide approaches offers another opportunity to hand over proven pilot interventions to the Government for scaling up.

35. **Adjustments made.** The education, development and protection programme was divided into two programmes reflecting new, separate national policies. The adolescent participation and development project was discontinued and its activities absorbed into the HIV/AIDS and child participation programme. Other changes included the establishment of a protection post, phased exit from direct management of warehousing, and redefining of some posts.

36. Adjustments to the child survival programme include a greater concentration on the leading causes of death, including HIV/AIDS, and the convergence of IMCI and maternal health activities into four health districts that can "showcase" results. The programme shifted its attention from traditional birth attendants to the setting up of emergency obstetric care in the four districts, and results were redefined. Objectives for the HIV/AIDS and child participation, and social planning and rights advocacy programmes, were made more results-based.

37. The education and development programme's objectives were aligned with the new national Education Strategy, with a stronger focus on girls and OVCs. The protection programme has been considerably adjusted to emphasize the legal framework for child protection and support to OVCs.

Swaziland

38. **Introduction.** The Swaziland MTR was managed by a Coordinating Committee comprising members from UNICEF, the Deputy Prime Minister's office, sectoral ministries, the OVC network, NGOs, the National Emergency Response Council on HIV/AIDS, Parliament and children. Three technical working groups used field visits, community dialogues and a workshop to review progress and make recommendations. The national MTR meeting included the Deputy Prime Minister, the Minister of Economic Planning and Development, other government officials, chiefs, parliamentarians, religious leaders, and staff from NGOs, the United Nations and children.

39. **The situation of children and women.** The situation has deteriorated since the signing of the MPO in 2000, largely because of the HIV/AIDS pandemic, exacerbated by three successive years of drought. A national disaster was declared in early 2004, with more than one third of children needing emergency interventions. Malnutrition and U5M both increased. In 2002, according to sentinel surveillance, HIV prevalence was estimated to be 39 per cent. There are more than 60,000 orphaned children. The impact of the pandemic is aggravated by an almost stagnant economy and staggeringly high unemployment of at least 22 per cent, with higher levels among youth. Although Swaziland is categorized as a middle-income country, 68 per cent of its people subsist on about \$10 per month.

40. In 2003, 30 per cent of children of primary school age were out of school, compared with 20 per cent in 1990. Major reasons were lack of money for fees, care responsibilities at home, and the need to procure food.

41. **Progress and key results.** The country programme contributed strongly to realizing children's rights, especially in the case of OVCs. In 108 communities (the target was 55), local leadership initiated activities with network partners, and 57 of these communities created a cadre of neighbourhood-based volunteers to control and prevent child abuse. Applying lessons learned from an evaluation, 95 communities formed Neighbourhood Care Points (NCPs), enabling neighbours to care for OVCs. By the end of 2003, 198 NCPs were helping over 7,000 children. In two regions, the community IMCI initiative was linked to these NCPs.

42. Emergency funds from the European Commission Humanitarian Office provided material support to another 220 NCPs, for 11,000 children in 80 communities in humanitarian crisis. A school meal programme with Save the Children Fund (SCF) and the World Food Programme (WFP) reached 86 schools, and in these schools attendance and learning outcomes improved, and drop out decreased. Fifteen schools also benefited from an emergency water and sanitation intervention. Community grants for high-risk children were piloted in 44 of the poorest communities, benefiting more than 3,000 children and bringing national attention to this vulnerable group. Enrolment increased by over 20 per cent. Valuable partnerships were formed.

43. UNICEF worked with the Government and a Swazi NGO on guidelines integrating PMTCT into the health system. An education initiative trained 50 per cent of lecturers and 20 per cent of student teachers in HIV/AIDS, gender relationships, sexual abuse and exploitation. Twenty schools are bringing this initiative to other teachers, pupils and parents. Through the country programme,

NGOs trained peer educators, who reached 6,000 young people and their parents as well as 180 community-based teachers.

44. Evaluations showing the limited impact of previous communication approaches led to a new approach based on messages of hope, empowerment and responsibility. These were communicated through storybooks, videos, interactive storytelling methodologies, national campaigns, a national children's choir, and a documentary film. To make schools safer for children and prevent child abuse, protocols for training health workers and police were developed, and public advocacy efforts increased.

45. **Resources used.** The approved regular resources ceiling for 2001-2003 was \$3.30 million, of which \$1.98 million was allocated and \$1.84 million (93 per cent) were spent. A total other resources ceiling of \$8 million was approved, of which \$3.41 million was available as regular other resources, \$1.10 million as set-aside resources and \$1.58 million as emergency funds (\$6.09 million). Out of this, \$5.08 million (84 per cent) were spent. More funds have been committed for community IMCI, life skills education and PMTCT, which will raise the other resources budget about \$800,000 above the Executive Board ceiling. The difference will be accommodated under the Board-approved regional projects. Overall, the total country programme allocated funds available for 2001-2003 were \$8.07 million, of which \$6.92 million (86 per cent) had been spent at the time of the MTR.

46. Funding for the community action for child rights and mainstreamed emergency response programme greatly increased, from \$265,000 in 2001 to \$2.36 million in 2003. The total funded in 2001-2003 was \$3.92 million (49 per cent of country programme funds), and \$3.55 million was spent. Funding for the integrated basic social services programme also multiplied, from \$290,000 in 2001 to \$1.2 million in 2003. The 2001-2003 total was \$2.42 million (30 per cent of country programme funds), and \$1.96 million was spent. Funding for the policy advocacy and institutional support programme doubled from 2001 to 2003. The total funded in 2001-2003 was \$1.02 million (14 per cent of country programme funds), and \$.89 million was spent.

47. **Constraints and opportunities affecting progress.** Constraints included overstretched capacities of both UNICEF and implementation partners due to rapid emergency scale-up and staff losses. Implementation, participatory monitoring, quality control and coordination capacities all need strengthening to harness opportunities to replicate successful pilot projects. Future work should emphasize conducting a Situation Analysis, creating a National Plan of Action for Children, establishing effective national coordination mechanisms for children's programmes, and meeting reporting obligations to the Committee on the Rights of the Child.

48. The country programme took advantage of opportunities to adapt, scale up and forge new partnerships. International recognition of the emergency situation resulted in large increases in funding, enabling some targets to be surpassed.

49. **Adjustments made.** The country programme structure was slightly modified. The integrated basic social services programme now has specific health and education projects. The renamed action for children's rights programme now has both community and national components. Communication and monitoring projects under the policy advocacy and institutional support programme provide cross-cutting support. In 2004-2005, work will be consolidated in 55 communities, while

emergency funds will be used for OVCs in those and other communities. Fund-raising efforts, reduced in the face of implementation constraints, will be renewed as management capacity is strengthened.

50. The programme will emphasize community action plans and the strengthening of partnerships. PMTCT "plus", Community-IMCI, life skills and gender work will expand. By end-2005, NCPs will expand to 345 sites in the 55 focus communities. Child protectors will be expanded in partnership with a coalition working to combat sexual abuse. UNICEF will advocate for a national children's coordination mechanism and for a strengthened multisectoral approach. Government monitoring will be strengthened through use of *DevInfo*.

Uganda

51. **Introduction.** The Uganda MTR was led by the Government through a joint country programme management team, which guided six working groups. Each group reviewed achievements against expected results found in the MPO, the Uganda Poverty Eradication Action Plan, the Millennium Development Goals and the MTSP. Participants included ministries, local governments and Parish Development Committees, United Nations agencies, NGOs and community-based organizations. Methodologies included desk reviews, district meetings, workshops, site visits, and 12 studies and evaluations. The final MTR meeting was attended by two ministers, permanent secretaries and more than 70 other adults as well as children.

52. **The situation of children and women.** In the 1990s, Uganda achieved economic growth, poverty reduction, the introduction of universal primary education, reduction in HIV prevalence and increases in access to safe water. The Decentralisation Act and policy instruments such as the Poverty Eradication Action Plan, the Poverty Action Fund and the Northern Uganda Social Action Fund created an enabling environment for progress. Uganda ratified the Convention on the Rights of the Child and supports *A World Fit for Children*. A Children's Act is in place and there is a legal and policy environment for child protection. However, since the start of the 2001-2005 country programme, progress in improving key social development indicators has been slow, and the 17-year conflict in northern Uganda has worsened.

53. Primary school enrolment increased dramatically from 1996 to 2003, due to the introduction of universal primary education. However, 13 per cent of primary school-age children are not enrolled, and drop out rates remain high. Only 8 per cent of children from poor households can access pre-primary education, only 22 per cent of children complete grade seven, and only 20 per cent of children of secondary school age are enrolled.

54. The IMR (88 per 1,000 live births) and U5M (152 per 1,000 live births) have stagnated, and urban/rural differences remain pronounced. Stunting affects 39 per cent of children, and micronutrient deficiencies are endemic. The 2002 revitalization of the expanded programme on immunization (EPI) increased immunization coverage, though variation remains between districts. Uganda has the third-highest total fertility rate (6.9 births per woman) in the world, and the MMR remains unchanged at 505 per 100,000 live births. Only 39 per cent of births are attended by skilled personnel. Rural water coverage has increased but varies widely, from 25 to 74 per cent.

55. The decline in HIV prevalence rates appears to have halted, with prevalence hovering at around 6 per cent. AIDS accounts for 51 per cent of orphanhood; 15 per cent of children under 15 (2.1 million) are orphans. Out of 1.2 million live births per year, 25,000 are HIV positive, yet less than 10 per cent of pregnant women attend antenatal counselling sites with PMTCT services.

56. The situation in northern Uganda sharply deteriorated from 2001 to 2003. The number of internally displaced persons (IDPs) increased from about 500,000 to 1,400,000, and most have no access to essential services. An estimated 8,000 children were abducted and another 20,000 commute every night to sleep on town streets to avoid abductions and attacks.

57. **Progress and key results.** The success of the human rights-based approach to programming was demonstrated by several outcomes: strengthened capacity in 31 districts and 141 sub-counties to plan, deliver, and monitor services; strengthened capacity of 730 Parish Development Committees and 6,000 community mobilizers to support child-centred activities; strengthened capacity of district officials for decentralized implementation; increased focus on the 49 most disadvantaged sub-counties in 11 focus districts and strengthened partnerships and coordination at the national level for leveraging resources and developing social sector strategies, policies and programmes.

58. The rights to health and nutrition programme included the following results: Immunization against tetanus for 91 per cent of women of childbearing age in five high-risk districts; revitalization of immunization, vitamin A and IMCI programmes; some 13.5 million children immunized against measles; more than 6 million children received Vitamin A; DPT3 coverage increased to 72 per cent; improved latrine coverage; increased use of mosquito nets; and increased practice of 16 key behaviours for IMCI. The revamped Birth and Death Registration system now functions in 17,157 villages, where 17 per cent of children under eight (528,300) were registered.

59. The HIV/AIDS and rights to self-protection programme achieved several results. Life skills development and information-sharing reached 495 youth groups in 15 districts and 1,500 peer educators in 31 focus districts. In addition, PMTCT sites increased from 5 to 71 in 31 districts, with 224,410 pregnant women attending these sites, 71 per cent of whom were counselled and 65 per cent tested. PMTCT "plus", including care for seropositive mothers and children, has started. OVC protection, care and support initiatives were tested in four districts, following a new national policy and plan.

60. The child-friendly basic education and learning programme included the following results: operationalization of 250 ECD sites in 13 districts, benefiting 10,600 children; child-friendly environments established in 31 districts, benefiting 450,200 children; 341 alternative learning centres established; more than 100,000 out-of-school children attaining literacy; and more than 200,000 children involved in the Girls' Education Movement.

61. The school and community sanitation, hygiene and water programme contributed to the national achievement of providing more than 1.2 million children with improved access to water and latrines at school. The pupil-stance ratio for latrine use improved from 100:1 in 2000 to 64:1 in 2002, and 3 per cent of the reduction in girls' drop out was attributed to improved sanitation facilities. At the

community level, 218 trained water committees in 16 districts are maintaining water systems and 45,000 people have improved access to water from 48 protected springs, 141 shallow wells and 9 gravity flow systems.

62. The rights of children in armed conflict programme included the following results: mitigation of displacement-hardships for 53,000 households and 3,000 children; improved nutritional status of 600 children per month at therapeutic feeding centres; 60,000 children immunized against measles; 27,000 children provided with school materials; and 20,000 displaced persons provided with sanitary facilities.

63. **Resources used.** Of the \$15.68 million in regular resources allocated for 2001-2003, \$15.16 million (97 per cent) were spent in the following percentages: planning, Birth and Death Registration (BDR) and cross-sectoral support (29); rights to health and nutrition (17); school and community water and sanitation (16); child-friendly basic education and learning (15); HIV/AIDS and rights to self-protection (15); and rights of children in armed conflict (8).

64. A total other resources ceiling of \$45.8 million was set for 2001-2003, of which \$28.9 million were available and \$28.1 million (97 per cent) were spent in the following percentages: rights to health and nutrition (38); rights of children in armed conflict (16); BDR and cross-sectoral support (14); HIV/AIDS and rights to self-protection (12); child-friendly basic education and learning (10); and planning, school and community water and sanitation (10).

65. **Constraints and opportunities affecting progress.** Constraints are poverty, disease, including HIV/AIDS, high fertility, insecurity and limited access to conflict-affected areas. The country programme received only 65 per cent of its other resources ceiling, mainly because donors' funding shifted to direct budget support. This adversely affected almost all programmes. The Government's decision to include project-based funds in budget ceilings and the new fiscal decentralization strategy demand adjustments by UNICEF. Counterpart funding to focus districts is lacking.

66. The policy environment favours the realization of children's rights. The revision of the Poverty Reduction Action Plan presented advocacy opportunities for alignment of national goals with the Millennium Development Goals and MTSP targets. This is essential to reduction of child and maternal mortality, a priority. Universal primary education offers opportunities to reduce gender and other disparities. The sector-wide approach to budgeting offers opportunities to develop new partnerships and to raise strategic issues affecting children, using evidence-based lessons learned. Resources can be leveraged to help children in areas outside of the focus districts of UNICEF.

67. **Adjustments made.** The country programme is aligned with MTSP, although protection programming is implemented mainly in the conflict-affected areas. In response to the northern conflict, financial and human resources were reallocated for 2004-2005 to meet the UNICEF Core Commitments for Children in emergencies. The ongoing study on children in need of special protection may lead to protection issues being addressed more widely in the next country programme. The MTR noted the need to better coordinate early childhood activities.

68. The MPO objectives were redefined to be specific, measurable, achievable, relevant and time-bound, and organized in a clear hierarchical results framework. Partners' capacity gaps will be addressed in coordination, supervision, monitoring and reporting. The country programme will also use review findings on best

practices to institutionalize the human-rights based approach to programming, enhancing capacities of duty-bearers and disseminating information on best practices.

69. The programme will accelerate interventions to address inadequate maternal and child health services, low PMTCT coverage, the care, protection and support for OVCs, youth-friendly health services and scale-up of birth and death registration.

Major evaluations

Girls' Education: evaluation of Complementary Basic Education in the United Republic of Tanzania (COBET)

70. **Reasons for the evaluation.** The COBET programme piloted basic educational opportunities for out-of-school children, particularly girls, in five rural and urban areas through a curriculum focused on basic competencies and life and survival skills and offering flexible schedules for students. Results were expected to influence policies and assist national replication. The components were a participatory needs-assessment, empowerment and participation of stakeholders, strengthening institutional linkages, production of teaching and learning material and implementation through community-based committees.

71. The evaluation examined the achievement of objectives and assessed whether and how the approach could be expanded to all districts. Evaluation criteria were effectiveness, quality, adequacy and relevance.

72. **Design and methodology.** In all five pilot sites, purposive sampling was undertaken of learners, facilitators, community duty-bearers, district officials, and institutional partners. Design of data collection instruments and the analysis were guided by a conceptual framework for determining effectiveness.

73. Methodologies involved a contextual study through desk review and site visits; questionnaires for each sampled group; observation schedules; national standardized tests; language and mathematics achievement tests; a unit-cost data-collection instrument; tape-recorded focus-group discussions; individual and group interviews; and field observations. Responses to the learners' questionnaire and language and mathematics tests were assessed statistically for reliability and validity.

74. **Participants.** Participants included 161 out of 1,530 learners, 72 facilitators, parents, school committee members, village chairpersons, government officials, district officials, COBET focal points and staff members from two institutes of education, the Ministry of Education and Culture, NGOs and a Cooperative Union.

75. **Significant rights issues addressed.** The evaluation addressed the effectiveness of the project to develop the State's capacity to ensure development of institutions, facilities and services for children, to reduce drop out rates and to address children's right to education, including both formal and vocational. The rights of girls and of disadvantaged, vulnerable children were particularly addressed.

76. **Conclusions.** COBET reached its targeted group of vulnerable children, 45 per cent of whom were female. The average age was 14, and 64 per cent lived with either a single parent or with a non-parental relative. Some 80 per cent were working at wage or non-wage subsistence labour. The curriculum was appropriately designed in terms of organization, subjects covered, structure of the learning process, flexibility and duration. The learning process was child-friendly,

participatory, and adaptive to individual learners' abilities and needs. The standardized test results demonstrated that most graduates of the three-year COBET cycle achieved a level of knowledge equivalent to that of students who attended seven years of mainstream primary school. Unit costs were low compared with formal education.

77. Problems included weak community ownership, diminishing sustainability, the lowering of learning ability caused by disadvantaged home environments, and persistent gender disparity in performance. Adaptations needed for replication and scale-up were identified. The programme's success prompted reflections on expanding alternative education to more children and on incorporating elements of COBET into mainstream education.

Fighting HIV/AIDS: evaluation of the peer education programme in Zambia

78. **Reasons for the evaluation.** The peer education programme was piloted in 47 zones to increase awareness, knowledge and safe behaviour concerning HIV/AIDS and reproductive health among young people in and out of school. The evaluation's objectives were to assess the impact of the programme, compile a list of best practices, recommend replication strategies, and develop a practical monitoring and evaluation framework and tools.

79. **Design and methodology.** The design covered four districts in two provinces where the programme had operated longest. It combined an impact evaluation with capacity-building for implementing partners in monitoring and evaluation. Methodologies included desk review, semi-structured interviews, focus-group discussions, questionnaires, and observations of anti-AIDS club activities. The respondents were selected to represent both school-based and community-based club members, high- and low-performing clubs, and areas of differing proximity to a district centre.

80. **Participants.** Participating were 349 club members as well as 55 cooperating partners, 20 zonal and 4 district coordinators, 7 staff from the implementing organizations and 4 UNICEF staff.

81. **Significant rights issues addressed.** The evaluation assessed the extent to which young people are fulfilling their right to information for their health and well-being and their right to health.

82. **Conclusions.** Information and supplies were insufficient and materials largely inappropriate. Rural sites were disadvantaged compared with urban sites. Drama, songs and the mobile video van were identified as the most effective media, but with insufficient funds they reached too few people. Though the peer approach was widely appreciated and well supported by local counterparts, its effectiveness was compromised by inadequate training, high turnover, lack of support for outreach and low motivation among volunteers. Project monitoring, evaluation and follow-up needed strengthening. Among participants there was evidence of higher knowledge levels and increased capacity to discuss previously taboo topics, but findings were mixed in terms of behaviour change for safer sex; there was some reduction in risky behaviours but teenage pregnancies, abortions and early marriages remained numerous.

83. Weaknesses in implementation and management rather than in the approach limited the programme's impact. Therefore, restructuring was recommended, including use of referrals to youth centres, better feedback systems, formation of

Youth-Friendly Corners in schools, redistribution of funds to more effective components and resolution of other management problems.

Fighting HIV/AIDS: a review of linkages between HIV/AIDS and nutrition interventions in Malawi

84. **Reasons for the evaluation.** Malawi is challenged by a complex, long-term emergency caused by HIV/AIDS (the HIV prevalence rate is 16 per cent), food insecurity, and poverty. These mutually reinforcing, negative factors increase households' vulnerability to shocks and decrease coping abilities. In 2002, a state of emergency was declared. In response, numerous organizations, including UNICEF, are involved in food assistance, HIV/AIDS prevention and mitigation. The evaluation was designed to address a perceived lack of convergence in policies, strategies and interventions, and the consequent failure to maximize the effectiveness of interventions.

85. **Summary of design and methodology.** A conceptual framework delineated the interactive, downward-spiralling relationship of poverty, malnutrition and HIV/AIDS. The evaluation covered these areas: implementation, targeting, commodities and resources, capacity, monitoring and evaluation, information, education and communication materials, and research needs. The methodologies included a desk review of policies and strategies, a descriptive, six-element inventory of food-assistance programmes associated with HIV/AIDS, key informant interviews and a workshop.

86. **Participants in the evaluation.** Among the 60 participants were people from 30 NGOs and government and United Nations agencies (UNICEF, the Food and Agriculture Organization of the United Nations and WFP).

87. **Significant rights issues addressed.** The evaluation considered the extent to which the programmes enabled the State to fulfil children's right to the enjoyment of the highest attainable standard of health, including combating disease and malnutrition, and providing health care services.

88. **Conclusions.** Malawi needs a strategy, policy or guidelines on nutrition and food assistance relating to HIV/AIDS. Current strategies are not integrated, and programmes are inconsistent and poorly defined. They lack a long-term orientation to the escalating food needs of people on a continuum of HIV infection or who are affected by HIV/AIDS. The spectrum of needs, from prevention to care and support, requires a coordinated package of services, with special attention paid to women and children. Along the continuum of infection, changing needs necessitate a holistic approach of interlinking interventions that include economic assistance, care and support, health and nutrition.

89. The evaluation recommended improvements in programme design and implementation, including increased participation of people living with HIV/AIDS. Key questions to be addressed are: who is being helped and for what purpose, what kind of assistance is needed and when should it begin and end. Each target group and objective requires a different kind of food basket tied to different kinds of HIV/AIDS interventions. Clearer programme objectives and linkages would help solve problems with staff training and burnout, weak monitoring and evaluation, and inappropriate information, education and communication materials. Practical,

Malawi-specific research is needed on community-support networks, defining appropriate food baskets and household vulnerability.

Integrated ECD: a rapid evaluation of community-based approaches to nutrition, IMCI and ECD in Madagascar

90. **Reasons for the evaluation.** An integrated nutrition and IMCI programme began in a few sites in 1994, and by 2002 had expanded to 644 sites in 25 health districts. Though it covers 3 per cent of the population, the initiative has been replicated by other development partners, who work in more than half the country. Beginning in 2001, the approach added ECD components in 9 districts. The evaluation was commissioned to determine the justification and parameters for a continuation of the integrated, community-based approach to nutrition, IMCI and ECD. The evaluation was to look at effectiveness and efficiency in achieving results, assess the sustainability of the process and make recommendations for the new country programme.

91. **Summary of design and methodology.** The study design sampled seven sites in five districts. Sampling criteria were duration of the programme, number of volunteers, accessibility to health services, inclusion of the IMCI component, participation of an NGO, and level of activities. Primary data collection was done through focus-group discussions with mothers of small children, volunteer workers, in-depth interviews, and a quantitative survey of 20 randomly selected mothers with a child under age 3, who participated in programme activities. Secondary data analysis was made from a review of 25 randomly selected growth records from each site, volunteer registers, the government database on nutrition and IMCI and the financial reports of UNICEF.

92. **Participants in the evaluation.** Participants were mothers, volunteers, village and municipal authorities, government officials, agricultural extension workers, nutritionists, health centre and district health workers, medical inspectors, NGO staff, government counterparts and UNICEF staff.

93. **Significant rights issues addressed.** These included: the capacity of the State to assist parents with child-rearing responsibilities as well as children's rights to enjoy the highest attainable standard of health and to develop to their fullest potential.

94. **Conclusions.** Despite high political commitment to decrease malnutrition, programme effectiveness and efficiency were weak, with low coverage, a failure to reach the most vulnerable children, poor community and local government involvement, lack of integration across activities, poor training, little or poor supervision and nonfunctional monitoring and information systems. The exceptions to some of these negative findings were sites where NGOs, rather than government agencies, were implementing the approach. Major recommendations were to focus on the most vulnerable, develop and strengthen partnerships with NGOs and revitalize the programme before investing in going to scale.

Immunization: evaluation of the vaccination cold chain in Madagascar

95. **Reasons for the evaluation.** The evaluation was to provide crucial information needed to re-launch the EPI in Madagascar, including where to concentrate rehabilitation efforts for rolling stock, management and logistical

capacities and whether it was feasible to introduce new technologies, such as propane gas and solar energy.

96. **Summary of design and methodology.** Partners agreed on a survey protocol covering 2,830 (80 per cent of total) health facilities in six provinces and 111 districts. A pre-tested questionnaire was designed with matching data entry screens in *EpiInfo*. Trained teams oriented district supervisors on administering and compiling the questionnaires. The data were analyzed according to an agreed-upon plan.

97. **Participants in the evaluation.** Health workers completed 2,268 questionnaires, which were compiled by supervisors. Partners included the Ministry of Health, UNICEF, and the World Health Organization.

98. **Significant rights issues addressed.** The evaluation results improved capacity in reducing infant and child mortality and in addressing children's right to health.

99. **Conclusions.** Key findings were that nearly 10 per cent of active cold chain appliances did not conform to minimum standards; 25-60 per cent of refrigerators were broken; the introduction of propane gas would reduce energy costs by 30 per cent; 80 per cent of motorcycles were broken down; and technical assistance was needed for restructuring, planning and budgeting the logistics system. The evaluation specified 29 actions needed in the stocking of vaccines, securing energy sources, cold chain maintenance and transport and logistics management. An estimated budget was provided for a rehabilitation plan.

Protection: evaluation of the joint training programme on the prevention of sexual exploitation and abuse of women and children in the humanitarian response to the food crisis in Southern Africa

100. **Reasons for the evaluation.** The WFP, UNICEF and SCF-United Kingdom commissioned a private company to develop a training package and implement a training programme to address issues of sexual exploitation, abuse and vulnerability to HIV/AIDS in the context of the humanitarian crisis in Southern Africa. Nearly 5,000 participants in seven countries were trained in 2002-2003, including 87 trainers and 243 managers who are training others in their countries. The evaluation addressed implementation, the collaborative approach and preliminary impact.

101. **Summary of design and methodology.** The training programme was evaluated in three countries (Malawi, Swaziland and Zimbabwe) in terms of its extent, appropriateness and effectiveness; the management and impact of the training; and collaboration among the joint regional management team, the country teams and participants. The methodology was predominantly qualitative due to the failure of the implementing agency to conduct pre- and post-training assessments. A short attitudinal instrument and semi-structured interview schedules were used, and all available documentation was reviewed.

102. **Participants in the evaluation.** The 120 participants included WFP, UNICEF and SCF-United Kingdom staff, implementing company staff, trainers, country management teams, trainees, governmental stakeholders, and a wide range of people involved in food distribution, from managers to truck drivers and community members.

103. **Significant rights issues addressed.** The central issue was the right of children and women to be protected from coerced, unlawful and exploitative sexual activity.

104. **Conclusions.** The problems encountered in the collaborative, joint agency management at regional and country levels were solvable, and the framework worthy of replication. Despite some improvements needed in the training materials, the core messages were communicated effectively, awareness was raised and a process of change was stimulated. The evidence demonstrated a positive impact on the targeted organizations and communities. New codes of conduct and training and awareness-raising materials are being developed, and issues raised in the training are being addressed. The programme was successful and effective in terms of both process and impact, and there is strong demand for its continuation.

Conclusion

105. The 2003 MTRs and evaluations addressed all of the MTSP priorities and strategies, as well as regional and national priorities. As joint programming through strong UNDAFs becomes more widespread, joint reviews and evaluations are becoming more common. Evidence was collected and analyzed scientifically and findings and recommendations were applied to adjust ongoing programmes, scale up and replicate results, or in some cases, re-focus, consolidate and restructure programmes and activities. Among their conclusions were several key points: (a) the human rights-based approach enhances ownership, sustainability and relevance of local interventions; (b) ECD was unfocused and in need of restructuring; and (c) the negative interrelationship of HIV/AIDS and famine challenged programmes to become more holistic and to build strong partnerships.

106. The scope and quality of evaluations done in 2003 were better than those done in 2002, and findings were more valuable for improving performance. Nevertheless, there is room for improvement, particularly in making linkages to expected results and indicators in MPOs. This is being pursued through several means: capacity-development of staff in both monitoring and evaluation and results-based planning and management; dissemination of evaluation standards and guidance; dissemination of MTR and monitoring and evaluation toolkits; the expansion of a regional database of consultants; extensive review of terms of reference by the regional office; and advocacy for more time and money allocated to ensure quality of work.

107. Most of the evaluations and all of the MTRs completed in 2003 effectively involved national and subnational stakeholders and community members (both children and adults) in assessment, analysis, and recommendations for action. The frequent teaming of international and national consultants increased national capacity for international-standard research and analysis. There is already evidence that the 2004 MTRs are benefiting from lessons learned in the 2003 exercises.